acting insulin and suggests that the absorbed insulin is biologically active.

On the other hand, measurement of plasma insulin levels in healthy subjects may not accurately reflect insulin absorption kinetics under all circumstances. Firstly, circulating levels of plasma insulin in healthy people are the sum of endogenous plus exogenous insulin and do not reflect the amount of absorbed insulin alone. This is important, since exogenous insulin is shown to decrease endogenous insulin secretion in the normal person.[7] Secondly, serum insulin levels are affected not only by the rate of insulin delivery but also by the rate of insulin clearance. Factors which may affect insulin clearance regardless of their effect on insulin absorption may affect plasma immunoreactive concentrations after insulin injection. Furthermore, owing to the rapid turnover of insulin, plasma insulin levels at a given time represent only a minor portion of subcutaneously injected insulin.[8 9] Thus under circumstances of altered endogenous insulin secretion or changed metabolic clearance of insulin the determination of serum insulin levels as an index of insulin absorption kinetics is subject to error.

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Jejunoileal tuberculosis

SIR,—In their report on jejunoileal tuberculosis, Dr Caroline Humphreys and others (12 July, p 118) state that the differential diagnosis of Crohn's disease and gastrointestinal tuberculosis is difficult and requires a high index of suspicion. It is my opinion that the diagnosis could have been entertained if the purified protein derivative (PPD) reactivity had been tested prior to starting therapy with corticosteroids. The time-honoured practice of testing patients before immunosuppression has to be emphasised because in similar situations it has a two-fold purpose: firstly, it brings up the possibility of gastrointestinal tuberculosis[1] and, secondly, will determine need for isoniazid prophylaxis.[2]

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Acupuncture and postherpetic neuralgia

SIR,—We would like to add to the reply to your question about acupuncture (26 July, p 283). One of us (GL) has treated about 20 patients suffering from established postherpetic neuralgia with acupuncture. Many of these had had invasive or destructive procedures prior to the acupuncture treatment, but despite this approximately 40% seem to have gained significant pain relief from acupuncture.

We realise, however, that this is no more than a clinical impression. We are establishing a trial to prove, or disprove, the efficacy of acupuncture in postherpetic neuralgia. This trial will be starting towards the end of this year and will draw patients from the Southampton area. Acupuncture will be compared with an equally magical placebo, and the effects will be assessed by a non-treating doctor (JF). We would be happy to provide protocols for doctors who are interested, and would be grateful for criticism of our methodology.

We feel that the case for steroids and other antiviral agents in the treatment of either shingles or the prevention of postherpetic neuralgia is unproved. In China acupuncture is given to all patients suffering from acute shingles, and this may explain the extremely low incidence of postherpetic neuralgia. Perhaps it is more reasonable to suggest that patients should receive a course of acupuncture during the acute shingles?

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Medical audit

SIR,—I agree with Sir Cyril Clarke (16 August, p 514) that the Senior Hospital Medical Staff Conference's rejection of the CCHMS's proposals for medical audit should not be interpreted as hostility to the principles of quality control. There are certainly many hospitals in the UK in which regular case discussions, clinicopathological conferences, and death reviews are a firmly established feature of the postgraduate scene. I would depart from Sir Cyril's remarks only in emphasising that such reviews have in many instances been going on for more than a quarter of a century and not simply, as he suggests, since the initiation of the Medical Services Study Group. But I have little doubt that that group has given encouragement to many physicians.

I am sure that collaborative research can be a valuable promoter of healthy self-criticism and that it should be more widely encouraged on a regional and national basis. The Royal College of General Practitioners has done some useful work on these lines, and so has the Medical Services Study Group of the Royal College of Physicians of London, for which Sir Cyril and his colleagues have been responsible. The Royal College of Surgeons of England has received encouraging financial support for developments on similar lines: many of us are hopeful that this will lead to collaboration with the specialist associations and other interested groups and individuals.

The essence of success in collaborative research, and indeed in all forms of quality control, is that it should stem from the free and willing co-operation of enthusiastic doctors. One can persuade, but should never compel, the unwilling and the sceptical to join in. If this concept of collaborative research between consenting adults in private should seem too weak a potion for those who talk so glibly of compulsory audit, let it be clearly recognised that any politically inspired and bureaucratic "big brother" would be wholly inimical to promoting the economics of excellence in medicine.

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Advertisement from group of homosexual doctors

SIR,—The *BMJ* recently refused to publish an advertisement from a group of homosexual doctors. The aim of the advertisement was to contact other homosexual doctors to discuss matters of mutual concern. The decision was defended at the Newcastle Annual Representative Meeting, on the grounds that it would be offensive to most doctors reading the journal. The fact that no one spoke in public in favour of the advertisers might be taken to indicate the absence of any doubt about the issues involved. It is conceivable that potential speakers were worried about the personal consequences of being branded as homosexual themselves. It is clear that the discussion was rather limited.

It needs to be pointed out that a similar group existed in 1976-7, based at the University of London Union. After a year's painstaking work this group produced a document describing counselling facilities for homosexual people in distress. It then distributed the document to over 10 000 general practitioners in London. Is this kind of work really offensive?

That there are homosexual doctors must be accepted universally. If it is this that gives offence the choices are clear: the profession must go on being offended indefinitely, or attempt to remove all homosexual doctors from practice. I do not believe that this is the aim of the BMA. It seems on the surface that offence is really given by the thought of homosexual doctors talking to each other and publicising their existence. What prompts this reaction, which is at the same time harsh and dishonest? It must be that the offence that has been given to homosexual doctors (and patients) is either unrecognised or discounted. Is it surprising in this atmosphere that some homosexual doctors pretend to be heterosexual and that some homosexual patients are wary of doctors in general?

I do not believe that the majority of doctors are offended by the thought of such an advertisement. In fact, I believe that a great many might find the issue rather uninteresting. So it would be if only the journal had published the advertisement, and if only the profession had not been misrepresented in public by appearing to express unanimous disapproval. Ultimately, though, if doctors could stop being offended by each other in this way we could all get on with the work of medicine.

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Dumfries and Galloway: where the NHS works well

SIR,—I have read with much pleasure the article by a "Special Correspondent" (9 August, p 438). I write in reply because I had the good fortune to be in Dumfries for one year. In October 1930 I became assistant to the "legendary practitioner Dr Gordon Hunter." I can thus vouch that he "provided